

Case Number:	CM15-0028903		
Date Assigned:	02/20/2015	Date of Injury:	11/20/2006
Decision Date:	04/01/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/17/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Ohio, North Carolina, Virginia
Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 59 year old male, who sustained an industrial injury on 11/20/2006. The diagnoses have included displacement lumbar disc without myelopathy, degenerative lumbar or lumbosacral intervertebral disc and lumbago. Treatment to date has included opioid medications. Currently, the IW complains of constant, dull, throbbing pain in the middle of the low back. The pain radiated into the right buttock and into the posterior thigh to the posterior knee. Pain was rated as 8/10 without medication and 5/10 with medication. Objective findings included a stiff antalgic gait due to pain. He is able to transfer from sit to stand with guarding and stiffness. He has functional range of motion of lower extremities and 5/5 strength right and 4/5 left. Reflexes of knee are 3/4 bilaterally. He has decreased sensation to light touch in lower extremities, increased on right to left. Back flexion is 60 degrees and extension is 10 degrees. He is non-tender to palpation in the spinous processes of lumbar region. On 1/16/2015, Utilization Review non-certified a request for Opana IR 10mg #120, Flexeril 10mg #90, and Opana ER 40mg #90 noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS was cited. On 2/17/2015, the injured worker submitted an application for IMR for review of Opana IR 10mg #120, Flexeril 10mg #90, and Opana ER 40mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Opana IR 10mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids specific drug list, On-Going Management, weaning of medications Page(s): 93, 78-80 and 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Those prescribed opioids chronically require ongoing assessment for pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Opioid doses should not exceed 120 morphine equivalents per day unless directed by a pain management physician. There should be a risk assessment done for possible addiction for those taking opioids chronically. In this instance, there are no pharmacy reports or urine drug screens submitted for review. The dose of opioids vastly exceeds the daily recommended maximum of 120 morphine equivalents. It appears that stimulants have been prescribed possible off-label to combat the sedation from the opioids. Currently the dose of opioids approximates 480 morphine equivalents per day. However, the physician and patient have agreed to a slow opioid wean. The IW has been prescribed 30 less Opana IR tablets per month every 3 months, for the last 6 months. This translates to 10 mg less of Opana (or 30 less mg of Morphine) per day. While this strategy amounts to weaning roughly 18% of the opioids every 3 months. The guidelines call for a 10% wean every 2-4 weeks, or 30% every 3 months for those with high tolerance or addiction. While the current strategy is not quite as aggressive as that recommended, it seems reasonable given that the injured worker lives out of state and must return every 3 months. Therefore, Opana IR 10mg #120 is medically necessary.

Flexeril 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants(for pain), anti-spasmodic Page(s): 63 and 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant that is marketed as Flexeril by Ortho McNeil Pharmaceutical. It is recommended as an option for pain, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. Most guidelines limit the use of Flexeril to 2-3 weeks. In this instance, it is evident that cyclobenzaprine in one form or another has been in use for a duration which exceeds that recommended by the guidelines. therefore, Flexeril 10 mg #90 is not medically necessary.

Opana ER 40mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids specific drug list, On-Going Management, weaning of medications Page(s): 93, 78-80 and 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Those prescribed opioids chronically require ongoing assessment for pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Opioid doses should not exceed 120 morphine equivalents per day unless directed by a pain management physician. There should be a risk assessment done for possible addiction for those taking opioids chronically. In this instance, there are no pharmacy reports or urine drug screens submitted for review. The dose of opioids vastly exceeds the daily recommended maximum of 120 morphine equivalents. It appears that stimulants have been prescribed possible off-label to combat the sedation from the opioids. Currently the dose of opioids approximates 480 morphine equivalents per day. However, the physician and patient have agreed to a slow opioid wean. The IW has been prescribed 30 less Opana IR tablets per month every 3 months, for the last 6 months. This translates to 10 mg less of Opana (or 30 less mg of Morphine) per day. While this strategy amounts to weaning roughly 18% of the opioids every 3 months. The guidelines call for a 10% wean every 2-4 weeks, or 30% every 3 months for those with high tolerance or addiction. While the current strategy is not quite as aggressive as that recommended, it seems reasonable given that the injured worker lives out of state and must return every 3 months. Therefore, Opana ER 40 mg #90 is medically necessary.